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TOBACCO ALERT

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EDITORIAL

TOBACCO CONTROL HOTLY DEBATED IN POLAND

Nowhere in the world is the tobacco epidemic more serious than in Eastern Europe, and nowhere in Eastern Europe is it more serious than in Poland. WHO estimates that over 100 000 deaths per year are attributable to tobacco use in Poland. But the problem is not yet getting better; in fact, it is getting worse. These deaths will all occur among people over 35, most of whom started smoking more than two decades ago. Unfortunately, large numbers of Poles under 35 are now taking up the cigarette habit, and, inevitably large numbers of them will be killed by their habit when they reach the middle and older years of life.

There can be no doubt that the implementation of a free market economy will bring many benefits to the economic and social life of Poland. Already, many of these benefits are being realized. However, along with a free market economy has come barely restrained tobacco marketing, enticing young Poles into a lifetime of cigarette addiction. Unhappily, many have succumbed to the lure of the tobacco advertisements, and tobacco use shows no sign of decreasing among young people in Poland. More than half of Polish men and more than one-third of Polish women smoke.

Fortunately, Poland has a strong and active public health community that is determinedly working to reduce the toll of the tobacco epidemic in Poland. But, as in many other countries, public health interests confront those in favour of perpetuating and even increasing tobacco use. Transnational tobacco companies have invested heavily in Poland, and it is estimated that annual tobacco company earnings in the country are approximately US $100 million. Ironically, this is more than twice the amount that the World Bank and the International Monetary Fund made available in 1992 for improvements to the Polish health care delivery system.

Still, significant public health progress is being made. Many Polish cities including Cracow, Gdynia, Gdansk, Bydgoscz, Olsztyn and the Wola district in Warsaw have adopted measures to restrict or prohibit smoking in many public places. More importantly, a draft of a comprehensive tobacco control law of the sort currently in place in France, Canada, Finland and many other countries has been introduced into the Senate, the Upper Chamber of the Polish Parliament. Hopefully, it will receive due consideration from both the Senate and the Sejm, the Lower House of Parliament, and emerge in the near future as an effective tobacco control law for Poland.

The draft law proposed a ban on tobacco advertising, effective protection from involuntary exposure to tobacco smoke in public places and workplaces, and a portion of tobacco taxes dedicated to tobacco control and other public health measures. Similar dedicated taxes are in place in some states of Australia, Finland, Portugal and some states of the United States. Interestingly, a recent public opinion poll found that over two-thirds of Poles would support such a tax if the proceeds were spent on health education and promotion programmes in favour of a smoke-free life. (continued on page 3)

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WHO/TOH PROGRAMME

THE NEW ACTION PLAN FOR A TOBACCO-FREE EUROPE 1992-1996

The World Health Organization's Regional Committee for Europe decided in September 1992, in Copenhagen, to promote stronger Europe-wide action on tobacco when it discussed the second European Action Plan on Tobacco. The new Action Plan for a Tobacco-free Europe puts forward 37 measures in six areas. The plan deals with tobacco taxation and subsidies, product liability, control of tobacco advertising promotion of smoke-free public places and workplaces. European countries were urged to review their national action plans accordingly, and to allocate the necessary resources to tobacco control. A strategic alliance of intergovernmental and other international, national and nongovernmental organizations and networks will be called upon to become partners with WHO in the new Action Plan.

The first phase: 1987-1991

The first European Action Plan on Tobacco was approved by the WHO Regional Committee in 1987. The following year, the First European Conference on Tobacco Policy in Madrid set out 10 strategies to attain a target of 80% nonsmokers in Europe. A key task was to gain effectiveness through collaboration, mutual support and action.

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EPIDEMIOLOGY

HEALTH EFFECTS OF TOBACCO USE IN EUROPE

Almost all countries in the European Region have completed the epidemiological transition from a cause of death structure dominated by infectious and parasitic diseases to one where the chronic diseases predominate. As a result, typically less than 3% of deaths occur among children (0-14 years), while more than 70% of deaths occur among the elderly (65 years and over). With the postponement of deaths to progressively higher ages, the population structure of the Region is characterized by a high and rising proportion of elderly people.

The WHO European Region is unique in the sense that reliable, comprehensive cause-of-death data are routinely available for virtually all countries, with more than 95% of deaths in the Region being captured by national vital registration systems. As a result, it is relatively easy to monitor changes in causes of death associated with smoking. However, since not all mortality from the major smoking-related diseases such as lung cancer, ischaemic heart disease and chronic bronchitis/emphysema, is attributable to smoking, cause of death data provide only an approximate reflection of the extent of the tobacco epidemic. For causes such as lung cancer, which are exceptionally rare among non-smokers, the vital registration data provide a very good estimate of smoking-attributable mortality. For others, and in particular the major vascular diseases, smoking is only one, albeit a major, risk factor for the disease.

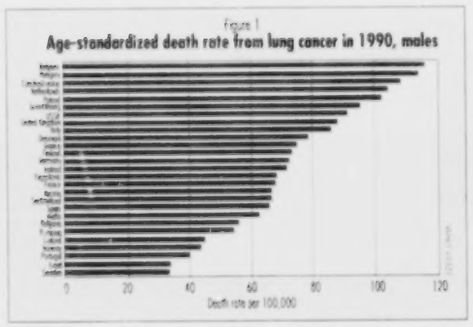
In order to determine the excess mortality of smokers from various diseases, studies which compare their mortality experience with lifelong non-smokers are required. These tend to be complex and expensive, and hence are not very common, even in Europe. One can, however, indirectly estimate the patterns and trends of smoking-attributable mortality in Europe by suitable scaling the excess risk ratios for smokers versus nonsmokers observed from other countries, where such studies have been carried out, and applying them to the vital registration returns. The World Health Organization has recently collaborated on a study to prepare such indirect estimates, based on the large-scale prospective study carried out by the American Cancer Society (ACS) in the 1980s among one million Americans.*

*For further details on the data and methods used to estimate smoking-attributable mortality, see Peto, Lopez, et al. Mortality from tobacco in developed countries: Indirect estimation from national vital statistics. *Lancet* 339: 1268-1278 (1992). A detailed description of the ACS study, including characteristics of the cohorts followed, can be found in the 1989 Report of the US Surgeon General on *Reducing the Health Consequences of Smoking: 25 Years of Progress*.

ASSESSING THE EPIDEMIC

One of the major issues in assessing tobacco-attributable mortality is the comparatively long delay between persistent smoking and its full health effects, which generally occur several decades later. This is particularly true for lung cancer. Indeed, among men in developed countries, who have experienced the brunt of the lung cancer epidemic, the massive rise in lung cancer typically occurred well after smoking prevalence had reached its peak. Current lung cancer rates are thus strongly determined by the previous smoking histories of populations.

Figure 1
Age-standardized death rate from lung cancer in 1990, males



Given that lung cancer is extremely rare among non-smokers in countries of the European Region, the overall (age-standardized) level of mortality from the disease provides a very good indicator of the extent to which smoking is affecting health and survival in various populations. Figure 1 provides a ranking of countries, for which data are available, in terms of the observed lung cancer death rates for men around 1990.** By far the highest rates are observed in Eastern Europe and the Benelux countries. Death rates for men from lung cancer are continuing to rise at 2-3% per year in several countries of Southern and Eastern Europe, but appear to have peaked, at least for males, in Belgium, the Netherlands and Luxembourg. In the United Kingdom, where the male lung cancer epidemic was first apparent, death rates peaked in the mid-1970s and have been continuously declining since then, reflecting the progressive decline in smoking prevalence which began some years earlier. Lung cancer mortality is also falling rapidly in Finland, where tobacco control efforts have been a major component of public health policy for several years, and to a lesser extent, in Switzerland and Austria as well.

**Cause of death data in sufficient detail to compute age-standardized rates from lung cancer were not available at WHO headquarters for Albania, Turkey or the majority of former Republics of the USSR.

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EPIDEMIOLOGY

Among women, on the other hand, lung cancer rates are rising virtually throughout Europe as a consequence of the massive increase in cigarette consumption which has taken place over the last three or four decades. In those countries where female smoking first became common, namely Denmark, the United Kingdom and Ireland, lung cancer mortality is already comparatively high (that is, in excess of 30/100 000) and is rising at 2-4% per year. In many other countries of the Region, female lung cancer rates are rising at least as rapidly, although current levels of the disease are still relatively low due to the more recent adoption of smoking by women. In the Mediterranean countries, the effects of female smoking are even more difficult to perceive since women in these societies traditionally have not smoked. However, smoking prevalence among younger women is typically very high in several of these countries, and unless these women can be persuaded to stop, their lung cancer death rates will also begin to rise as they reach middle age.

If the effects of smoking in a given population are already quite apparent in terms of rising lung cancer rates, then it is reasonable to assume that smoking is also contributing to mortality from other diseases causally related to smoking, particular major vascular diseases and the chronic lung diseases. Indeed, the US Surgeon General has estimated that of the approximately 400 000 tobacco-attributable deaths that occurred in the United States in 1985, less than 1 in 3 (110 000) were coded to lung cancer. Smoking thus kills many more people from diseases other than lung cancer and recent studies have attempted to use the absolute excess lung cancer rate as a guide to the proportion of deaths from other diseases which could also be attributed to smoking.

Figure 2 shows the extent of tobacco-related mortality among males in Europe, based on the percentage of all male deaths which are estimated to be attributable to smoking.*

Five different groups of countries are identified in Figure 2. Belgium and the Netherlands comprise the group with the highest smoking-attributable mortality in Europe, with about one-third of all male deaths (and 40% of those in middle age, that is, 35-69 years) in 1990 estimated to be due to smoking. In the next group, which includes countries such as the United Kingdom, Hungary, Italy and Denmark, some 25-29% of all male deaths are smoking-attributable (with a higher proportion in middle age). Deaths due to smoking are progressively less important in other countries of the Region, being lowest in Israel, Norway, Sweden and Portugal, countries where male smoking prevalence has traditionally been lower than elsewhere in the Region.

Figure 2

Smoking-attributable mortality
(% of all deaths), males, 1990

Overall, in 1990, tobacco products are estimated to have killed more than 1 million men and about 200 000 women in the WHO European Region. This represents about one-quarter of all male deaths, making smoking much the most important cause of premature death in the Region. The proportion of the major causes of death attributable to smoking, of course, varies from country to country, depending on the maturity of the tobacco epidemic. On average, however, tobacco use is estimated to account for over 90% of male lung cancer deaths in 1990 (as well as two-thirds of female lung cancer deaths), about 40% of all cancer deaths among men (10% among women), 75% of male chronic lung disease deaths (45% among women), and 20% of all cardiovascular disease mortality among men (and about 5% in women).

Despite the very substantial levels of smoking-attributable mortality among men in the European Region, progress in controlling the epidemic can be, and has been made through comprehensive tobacco-control strategies. Perhaps the best example is the significant reduction in smoking-attributable mortality among men in the United Kingdom which has taken place over the last two decades. In many other countries of the Region, including Austria, Belgium, Finland, Germany, Sweden and Switzerland, the male epidemic of smoking-attributable mortality appears to have reached its peak, and, as in the United Kingdom, should soon begin to decline. The major challenge, however, as the United Kingdom experience clearly attests, is the rapidly rising epidemic of smoking-attributable deaths among women. Indeed, deaths from smoking among women appear likely to overtake those for men in the United Kingdom within the next decade and will rise significantly in many other countries of the Region in the near future unless tobacco control initiatives are successful.

*Data are not presented for females since, in view of their more recent smoking histories, the proportion of smoking-attributable deaths is still comparatively low, only exceeding 5% in Ireland (17%), the United Kingdom (15%), Denmark (15%), Hungary (10%) and the Netherlands (8%).

ECONOMICS

TOBACCO CONTROL LEGISLATION ADOPTED BY THE EUROPEAN COMMUNITY

It has been estimated that, by 1995, over 571 000 people will die every year in the European Community as a result of smoking.* Faced with this "smoking epidemic", the European Community has made the fight against smoking a priority within the context of its action plan against cancer – the "Europe against Cancer" programme – initiated in 1987.

The European Community has a mandate to adopt legislative measures in certain fields. These measures may take the form of regulations, directly applicable and binding on Member States; directives, binding on Member States but generally implemented through national legislation; and resolutions which are not binding on Member States. In particular, a number of legislative measures have been adopted which are aimed at controlling the use of tobacco products within the Community. These include measures regulating the following:

Labelling of tobacco products

The labelling of tobacco products is regulated by two European directives (Directive 89/622/EEC and Directive 92/41/EEC). Since January 1992, tar and nicotine yields must be indicated on cigarette packets and all tobacco products must carry the general warning "Tobacco seriously damages health". Cigarette packets must also carry an additional specific warning to be chosen from a set list. The warnings must be printed in the official language(s) of the country of final marketing and should cover at least 4% of each large surface of the unit pack, excluding the indication of the responsible authority. This percentage is increased to 6% for countries with two official languages and to 8% for countries with three official languages. The warnings should be clear and legible, printed in bold letters on a contrasting background. They should not be printed on a place where

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they may be damaged when the pack is opened or on a transparent wrapper or any other external wrapping.

By 1 January 1994, tobacco products other than cigarettes should also carry supplementary specific warnings.

Smokeless tobacco

Directive 92/41/EEC also introduces a ban on the marketing of certain tobacco products for oral use recently introduced and specifically targeted at a young market. The sale of these products is banned in all European Community countries since 1 July 1992.

Tar content of cigarettes

The tar content of cigarettes marketed in the European Community is regulated by an EC directive adopted in May 1990 (Directive 90/239/EEC). This directive states that the tar content of cigarettes marketed in the European Community should not exceed 15 mg per cigarette as of 31 December 1992, or 12 mg per cigarette as of 31 December 1997.

Smoking in public places

In July 1989, the EC adopted a resolution inviting all Member States to adopt measures banning smoking in public places and on all forms of public transport. The resolution foresees that in the event of conflict, the right to health of nonsmokers should prevail over the right of smokers to smoke. Unlike directives, resolutions are not binding on Member States but merely represent a guideline for action.

Advertising of tobacco products

The advertising of tobacco products on television is banned in all European Community countries since October 1991 (Directive 89/552/EEC).

The Commission has, furthermore, proposed to introduce a total ban on the advertising of tobacco products except within specialized tobacco sales outlets. A draft directive on this subject has already received the approval of the European Parliament in Strasbourg and the final decision now rests with the Ministers of Health of the EC Member States. Although this proposal has the support of the majority of Member States, three countries are forming a blocking minority (Germany, the Netherlands and the United Kingdom). This draft directive has been the object of intensive lobbying within the European Community by both public health organizations and the tobacco industry.

Taxation of tobacco products

Although the taxation of tobacco products does not fall under the responsibility of the public health sector, pressure has been put on economic and finance ministers to take account of public health concerns in debates on the harmonization of taxes in the European Community.

Three directives on tobacco taxation were adopted in October 1992 which define the taxation structure for tobacco products (Directive 92/78/EEC) and set certain minimum levels of taxation (Directives 92/79/EEC and 92/80/EEC) effective as of 1 January 1993. Taxes on cigarettes should, for example, represent a minimum of 70% of the final retail price.

*Peto, Lopez et al. *The Lancet*, 23 May 1992

NEWS BRIEF

ACTION PLAN FOR A TOBACCO-FREE EUROPE: PHARMACISTS AND CESSATION

"Pharmacists helping smokers to quit" is an initiative created by the WHO Regional Office for Europe and the Danish Pharmaceutical Association. It documents experiences and results of community pharmacy programmes to support smoking cessation. The concept was tested as a pilot project at 20 Danish community pharmacies in Spring 1992. Pharmacists took part in training sessions on cessation methods, and ran an eight-week course for smokers; smokers paid a fee for this service. The programme was so popular that some pharmacies had to establish waiting lists!

Results of an interim evaluation showed a 60% success rate at the last group meeting. Ninety-seven percent of group members were satisfied with the programme, 73% would like to participate in other groups at the pharmacy, and 85% considered the pharmacy a positive meeting site. Further follow-up will be necessary to determine how many participants have remained nonsmokers one year after the programme.

The next step is to promote international implementation of the project. An international guidebook for pharmacists has been produced to help pharmacies and pharmaceutical associations in different countries to adapt the project to local needs. The project shows how partners (Euro PharmForum, the Danish Pharmaceutical Association, the WHO Regional Office for Europe) can work together very effectively, each providing their unique input.

EPIDEMIOLOGY

TOBACCO USE IN EUROPE

By far the most common form of tobacco consumption in Europe is manufactured cigarettes. The prevalence of smokers of cigars and pipes only is much lower and in most countries these represent less than 10% of all smokers. Perhaps the most notable exception is Denmark where one-fifth of all smokers smoke cigars or pipes only. Moist snuff is also used, primarily by young men in Sweden and Norway, where prevalence at ages 15-24 years ranges from 10-30%.

International assessments of smoking prevalence must be made with caution in view of the likelihood of non-standard definitions and other biases. Depending on how a smoker is defined (for example, according to number of cigarettes smoked per day, frequency of smoking, cumulative lifetime consumption), the percentage of the population classified as regular smokers can vary significantly. Similarly, biases in the sampling procedure (such as, for example, surveying specific population groups), or in interview methods, can seriously affect the representativeness and comparability of smoking prevalence surveys.

Notwithstanding these caveats, data available to WHO suggest that for the Region as a whole, about 45% of males aged 15 and over, and about 25% of females at these ages, are regular smokers. Prevalence varies substantially among countries, and indeed, even within countries. In Greece, Hungary and Turkey, more than 60% of adult men regularly smoke cigarettes, and only slightly less than 60% do so in Spain (57%) and Poland (56%). Male prevalence is lowest in Sweden (25%), Finland, Iceland, Norway and the United Kingdom (32-36%). Smoking is significantly lower for women in all countries, with the exception of Iceland, Sweden and Denmark where prevalence for males and females is roughly the same. Only about 10% of women smoke in Portugal, Albania, Croatia, Lithuania and the former USSR, compared with 30-35% in Iceland, Ireland, the Netherlands, Norway, Poland, Spain and the United Kingdom, and 47% in Denmark.

There are also marked differentials in smoking prevalence according to age and level of education. **Figure 1** presents the average prevalence of smoking in the 12 European Community countries according to three broad categories of educational achievement. Data are presented separately for males and females, and by age groups. Quite different patterns emerge for men and women. Among younger men (that is, those aged 15-39), there is a clear and consistent gradient across educational groups, with prevalence being significantly higher among the lower educated, and progressively declining with higher educational achievement. Interestingly, at older ages, this gradient disappears with little difference between educational groups except for the lower educated among whom prevalence is still substantially higher than the remainder of the population. These data would seem to support the view that health promotion campaigns to control tobacco use have been most successful amongst younger, better educated men and have had much less impact on lower educational groups.

Among women, the patterns are even more complex. At ages 25-54, smoking prevalence is remarkably similar for all educational groups, but at a substantially higher level for younger (25-39 years) women than those aged 40-54 years. For women aged 15-24 years, however, the smoking gradient is the converse of what was observed for men, with prevalence being higher among better educated women. This could well reflect the continued influence of socio-cultural norms discouraging tobacco use among women in less affluent societies. At higher ages, relatively few women smoke, but even among older women it is the better educated who are more likely to smoke, again quite possibly due to traditional norms which have kept prevalence low among less affluent women.

This marked age-affect in female smoking prevalence is well illustrated by data for France shown in **Figure 2**. Whereas 40-50% of French women aged 15-39 years regularly smoke cigarettes, only 8% of those aged 55 years and over do so. A very similar age pattern is evident for Belgium, Greece, Spain and Portugal. Indeed, fe-

(continued on page 8)

Figure 1
Prevalence of smoking, by age, sex and education, EC countries, 1989

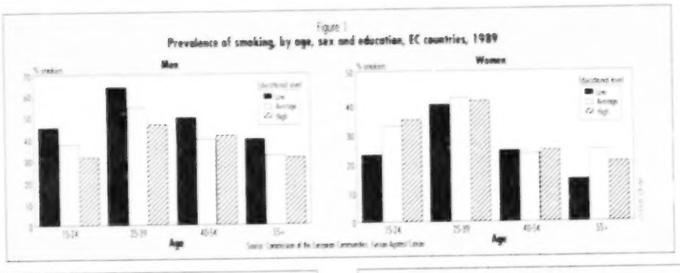


Figure 2
Female smoking prevalence by age, France, 1989

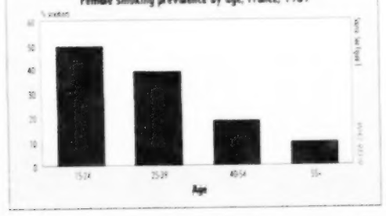
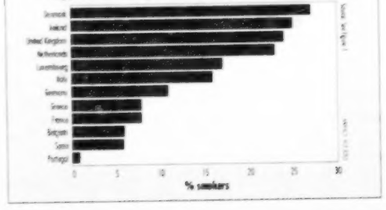


Figure 3
Smoking prevalence among women 55 years and over, EC countries, 1989



WHO/TOH PROGRAMME

THE NEW ACTION PLAN FOR A TOBACCO-FREE EUROPE 1992-1996

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The Action Plan called for a comprehensive approach to tobacco control. Joint action by government health and other professionals, the business sector, nongovernmental organizations, politicians and the media, would be needed to achieve success, a success that would also depend upon wide public support.

The tobacco policy conference held in Madrid, in 1988, created an unprecedented consensus on European action on tobacco by clarifying basic issues. This in turn generated enthusiasm among people working in governments and in international and nongovernmental organizations as well as among professional and lay people. Since 1987 cooperation between intergovernmental organizations and with nongovernmental organizations has been effected through regular planning and information-sharing sessions and the implementation of practical projects.

Situation in Europe

Since the launch of the first Action Plan, about 20 countries have adopted new tobacco control measures, and only about 10 have programmes suggested in the Action Plan.

The second evaluation of the Health For All (HFA) strategy showed that lung cancer remains the leading cause of cancer deaths in Europe, particularly among males and in eastern Europe. The annual average increase in lung cancer exceeds that for all other cancer sites. It remains the main contributor to the trend of total cancer mortality and largely negates reductions enjoyed in other areas of cancer mortality. However, countries with declining lung cancer mortality among males have demonstrated that the disease is preventable through decisive action on tobacco.

Consumption trends vary in Europe. Between 1975 and 1990, 12 countries showed a steady decline in tobacco consumption, with a further decline predicted. This encouraging trend applies to countries with low consumption levels, such as Finland, Sweden and the United Kingdom, and to those with relatively high consumption levels, such as Belgium, the Netherlands and Switzerland. On the other hand, a group of 13 countries showed no declining trend and some even showed further increases.

Various countries present a somewhat different picture of smoking. In countries of central and eastern Europe, the rate of smoking among males is high and that among females low but rising. In the north, there is practically no difference between men and women, and the rates are moderate with a slightly decreasing trend. In the south, the traditional smoking pattern is found with a big difference between men and women, a gap that is closing due to rising female smoking prevalence. In western European countries, smoking rates are moderate or high but the general trend is downwards.

The overriding concern, however, is that the European HFA target on tobacco will not be met if present trends continue. There will be very few if any countries in which 80% of the population are nonsmokers by the year 2000. Overall, the number of tobacco-related deaths is expected to increase, reaching more than 1.3 million Europeans annually by the year 1995.

Enhanced action: 1992-1996

The first Action Plan showed that comprehensive policies implemented through multisectoral action will prevent tobacco use and reduce disease and death. Therefore, countries need to take much more vigorous steps towards stronger tobacco control if the European target on prevention of smoking is to be achieved. The Regional Committee concluded in 1991 that it is necessary to continue the campaign on tobacco for a further five-year period from 1992 to 1996.

At its forty-second session on 17 September 1992, in Copenhagen, the Committee decided to promote stronger Europe-wide action to prevent the health damage caused by tobacco products. The Committee strongly supported the intentions and the goal set out in the new Action Plan for a Tobacco-free Europe.

The new Action Plan puts forward 37 measures in six areas: alliance-building, multisectoral tobacco policies, smoke-free environments, smoking prevention among young people, support to smokers for quitting and strengthening capacity for the implementation of policy (see table on page 7). The new plan envisages strengthening collaboration in Europe-wide campaigns and information exchange.

The strategic point is winning new allies and better cooperation with the old. In addition to individuals and organizations concerned with health, other sectors such as the ministries of finance, the sporting community and the media need to be involved. The Commission of the European Communities has been and would continue to be an important actor, ally and contributor to action on tobacco in Europe. The initiation of the first Action Plan was closely linked to support from the Commission.

Through the second Action Plan, the WHO European Region aims at creating, with the European Communities, a strategic alliance of the World Bank, UNICEF, UNDP, and other international and nongovernmental bodies. This alliance could effectively promote health in Europe through tobacco-free lifestyles.

The plan particularly aims at influencing policy-making and economics. The emphasis of the Action Plan is on implementing effective policies, such as controlling tobacco advertising, smoke-free public places, and tobacco taxation.

Several delegates at the meeting spoke strongly in favour of a ban on tobacco advertising and sponsorship and looked forward to a strong stand by the European Communities, in particular,

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on that issue. One delegate recounted from experience how legislative measures on tobacco have been a cost-effective strategy. They are often the only ones a country can afford.

Delegates of the countries of central and eastern Europe (CCEE) highlighted the efforts by the international tobacco industry to move strongly into CCEE. They saw themselves as especially vulnerable to aggressive tobacco promotion and strongly felt the pressure being put on governments to allow the tobacco industry to expand. Therefore, they were glad to hear of examples of effective measures to reduce tobacco consumption.

The Regional Office is already in the full process of generating and coordinating support to countries in central and eastern Europe (see article on page 9). For that purpose an international Task Force has been set up, country situations have been analysed, and a special implementation scheme has been worked out.

The Committee also urged Member States to develop or review their national action plans and to allocate the necessary resources to that end. Funding health promotion through tobacco taxation was presented as one way of securing resources, especially at a time when health care budgets are under serious strain. The Victorian Health Promotion Foundation (Australia), the Californian proposition 99 and the Finnish systems were quoted as being very effective.

"Health advocates are winning"

In April 1992, some European Member States felt that WHO could now leave its activities against tobacco; they felt it had played its role successfully and should move on to other subjects. But no other agency in Europe at present can play the role of independent advocate and initiate a strong strategic alliance against tobacco better than the Regional Office for Europe.

The Economist wrote recently that "health advocates are winning". WHO's budget and staffing for this activity can hardly compare with the investments of large tobacco multinationals – but broad support for health in countries can make a difference.

The six action areas of the Action Plan for a Tobacco-free Europe, covering the period 1992-1996

ACTION AREA	TARGET STATEMENT
Alliances for a tobacco-free Europe	Organization from all sectors working together at international, national and community levels must build new, strong alliances to intensify social and political support for a tobacco-free Europe.
Multisectoral tobacco policies	Multisectoral policies to prevent tobacco use should be strengthened throughout Europe.
Smoke-free environments	All public places, transportation areas and worksites throughout Europe should be free from tobacco smoke.
Nonsmoking generations	Comprehensive action should be taken to bring up European young people free from tobacco.
Support to smokers for quitting	Smokers who want to quit tobacco use should be able to obtain practical support in cities and towns throughout Europe.
Stronger leadership and implementation capacity	Each Member State should commit human and financial resources to tobacco control measures that will be sufficient to ensure their effective implementation and strong support for international cooperation.

EDITORIAL

TOBACCO CONTROL HOTLY DEBATED IN POLAND

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One clear lesson has already emerged from the still-unfolding debate on tobacco control in Poland. The international public health community must work together unreservedly and enthusiastically to support tobacco control efforts wherever help is needed. Right now, Poland needs the help of the international community. Already, the World Health Organization has shown strong support to Poland in its efforts to develop more effective tobacco control measures. For example, representatives from both the Regional Office for Europe and WHO Headquarters give keynote presentations to a symposium on options for tobacco control legislation held in the Polish Ministry of Health in December 1992.

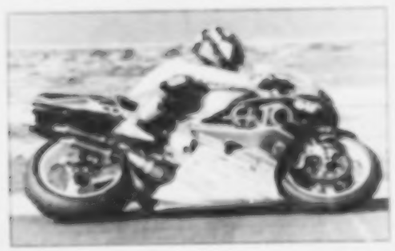
WHO, other international organizations and public health experts from other countries, can provide support to current national efforts to implement comprehensive tobacco control in Poland. If Poland succeeds in this endeavour, then it will have newly-acquired experience and expertise that can be made available to the next country that embarks upon serious measures to reduce tobacco-caused diseases. The Polish experience has already been studied in other countries in a similar situation. Through a widening circle of mutual support in the health sector, we can implement effective healthy public policies on tobacco at local, regional and national levels. Poland has taken the advantage of international recommendations, such as those decided by the World Health Assembly and described in detail by the WHO European Region in the Action Plan for a Tobacco-free Europe.

COUNTRY PROGRAMMES

SPONSORING IN CULTURE AND SPORT: TWO FIRSTS BY NGOs AND A PLAN FOR A FOUNDATION

First Rock Festival in Europe without tobacco advertising

In Geneva last November, two health promotion associations – CIPRET-GENEVA (Information Centre of the Association for the Prevention of Smoking) and FEGPA (Geneva Federation for the Prevention of Alcoholism) – jointly sponsored the "VERNIER-sur-ROCK" festival for young people, which thus became the first rock festival in Europe without cigarette advertising. These two NGOs, subsidized by the Department of Public Health of the Canton of Geneva, wanted to encourage the other sponsors who do not advertise addictive products to join in and take the place of the traditional advertisers. The event was a great success, very well received by the young people. It enjoyed great media coverage, far in excess of expectations.



World first in motorcycle grand prix

In February 1995, the two NGOs returned to the scene, sponsoring Serge David, the world's first competitor in the Continental 500cc motorcycle racing competition to race with the health concepts *I kiss non-smokers* and *Full of talent, not alcohol*. This unique sponsorship experienced some financial problems and pressures from certain economic interests, in a sport which is usually the preserve of cigarette advertising. The press gave the event good coverage, and it was a first breach in the cigarette and alcohol advertising monopoly. This sponsorship will certainly create interest in many countries where legislation to ban tobacco advertising is being considered.

A plan to establish a foundation for sport and culture

The Swiss people are to vote on popular initiatives calling for bans on tobacco and alcohol advertising, probably next spring. Cigarette manufacturers, with the support of some advertising agencies, have decried the economic consequences of such a decision. CIPRET-GENEVA, the Anti-Smoking Association in Berne and the Swiss Institute for Prevention of Alcoholism and other Addictions in Lausanne, have proposed the creation of a Swiss foundation for sport, culture and promotion of publicity (FSSCPP).

It would be funded by a tax on tobacco, an approach pioneered by the Victorian Health Promotion Foundation in Australia in 1987 and since emulated in many other jurisdictions. If the initiatives are accepted, a tax will be levied on every packet of cigarettes to support the Foundation. Twenty-five percent of the proceeds would be awarded to sporting and cultural associations in the form of direct sponsorships while the remaining 75% would be awarded to newspapers, cinemas and billboard companies, in the form of campaigns for promotion of health in its broadest sense through the promotion of sport and culture; this is a world first. Such an approach would be a credible economic alternative and would have the advantage of not penalizing the press and the advertising business. Its promoters maintain that it could sustain a real policy for culture and sport in Switzerland. It should be noted that such promotion would have a synergistic effect, encouraging other events with different sponsors. A parliamentary initiative to support the creation of such a foundation will be tabled in the near future.

EPIDEMIOLOGY

TOBACCO USE IN EUROPE

(continued from page 7)

male smoking prevalence among older women, as summarized in **Figure 3** for the European Community countries, is a very useful indicator of the maturity of the tobacco epidemic. Thus in the group of countries mentioned above, female smoking is a relatively recent phenomenon, and largely confined to younger and middle-aged women. As a result, smoking-attributable mortality is still comparatively low. In other countries, and in particular in Denmark, Ireland, the Netherlands and the United Kingdom, women have been smoking for much longer, as evidenced by the fact that about one-quarter of women aged 55 or more smoke. Not surprisingly, these are precisely the countries where female smoking-attributable deaths are already most apparent (see Epidemiology article on page 2).

The most relevant statistic for assessing the future course of the tobacco epidemic in Europe is smoking prevalence among youth. Virtually all smokers begin persistent smoking before age 25 and hence prevalence prior to this age, in the absence of effective smoking cessation measures, gives a very good indication of the likely future extent of the epidemic. On average, slightly less than 40% of males aged 15-24 years, and just over 30% of females of these ages, are regular smokers. As with overall prevalence, there are marked variations among countries with more than 50% of young men being smokers in Portugal, Spain, Greece and the former USSR, compared with one-quarter in the United Kingdom and Finland. More than 40% of all women aged 15-24 in Spain, France, the Netherlands and Denmark, currently smoke. Conversely, only about one in ten young women in the former USSR are regular smokers.

From this brief review, it is apparent that the prevalence of smoking varies widely in the European Region, in part due to the impact of socio-cultural norms which have traditionally discouraged female smoking. There is very clear evidence, however, that these norms are no longer preventing tobacco use among young women and as a result, a major epidemic of tobacco-related deaths will occur among European women unless tobacco control programmes prove more effective.

COUNTRY PROGRAMMES

TOBACCO OR HEALTH IN SIX COUNTRIES OF CENTRAL AND EASTERN EUROPE: REPORTS OF WHO TOBACCO OR HEALTH MISSIONS

In the new democracies of Central and Eastern Europe, aggressive marketing of tobacco products is rapidly being imposed on countries that already have high rates of smoking and smoking-related mortality. In many countries, transnational tobacco companies are being welcomed as creators of economic wellbeing, while public health concerns about the hazards of tobacco use are being shunted aside. In these circumstances, public health officials have sought help from WHO's Regional Office for Europe (EURO) to redress the balance in favour of public health.

The challenge was clear, and EURO responded. Calls went out from WHO for assistance from governments of countries of western Europe and major international non-governmental organizations. The governments of Finland, Sweden and France, together with the Nordic Council of Ministers, the International Union against Tuberculosis and Lung Diseases (IUATLD) and the International Union against Cancer (UICC), all responded positively by supplying experts to accompany WHO Tobacco or Health personnel from both the Regional Office for Europe and Headquarters on missions to several countries to strengthen tobacco control measures in central and eastern Europe. By March 1993, teams of experts, led by the WHO Tobacco or Health programme had provided on-site assistance with the development and implementation of tobacco control strategies in six countries of the Region – Hungary, Lithuania, Poland, Latvia, the Czech Republic and Slovakia.

Hungary

Of all the countries of Central and Eastern Europe, Hungary has one of the best records of progress towards the development of a market economy, but one of the worst records for tobacco consumption and tobacco-induced mortality. Privatization of industry has moved quickly. The first industry to be fully privatized? ... the tobacco industry. But while this rapid development of a private market economy is being applauded in many quarters, tobacco

is killing 25 000 Hungarians per year; nearly one-half of Hungarian men and nearly one-third of Hungarian women smoke. With aggressive Western-style tobacco marketing now taking place, the number of smokers can be expected to increase.

The WHO team that visited Hungary in November 1992, consisting of experts from EURO, Finland, Sweden, and the United Kingdom, reported that there was little knowledge or concern of the seriousness of the Hungarian tobacco epidemic in the country, apart from a handful of dedicated public health workers. Moreover, basic information needed for monitoring and controlling the epidemic was lacking, as were the personnel needed to do this work. In these difficult circumstances, one of the WHO/EURO team's key recommendations for a first step towards effective tobacco control was that the Hungarian Ministry of Health should strengthen tobacco policy and coordinate anti-tobacco actions. This recommendation was accepted and new resources were allocated to work on the problem, with the result that there is now improved potential for Hungary to move towards better control of its tobacco epidemic.

Lithuania

Tobacco consumption in Lithuania is characterized by very high rates among men (about 50%) and very low rates among women (about 10%). This consumption pattern is reflected in the tobacco-induced mortality statistics, with 6700 male tobacco-induced deaths in 1991 and only 400 female deaths from tobacco in the same year. The challenge for Lithuania, therefore, is to sharply reduce smoking among men, while ensuring that most women remain nonsmokers.

There are encouraging signs that Lithuania will rise to these challenges. An excellent tobacco prevention programme designed for use in Lithuanian schools has been developed by personnel of the Kaunas Medical Academy, but more resources will be needed to ensure that similar programmes are operating in all Lithuanian schools. In addition, a Draft Law on Tobacco Control in the Republic of Lithuania has been developed and has received consideration of a Lithuanian Parliamentary Committee, but has yet to receive consideration of the full Parliament. The WHO mission to Lithuania in November 1992 strongly supported the implementation of effective, comprehensive tobacco control legislation in that country.

Poland

The Polish tobacco epidemic is one of the most serious in the world, but key senior public health officials, in-

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COUNTRY PROGRAMMES

TOBACCO OR HEALTH IN SIX COUNTRIES OF CENTRAL AND EASTERN EUROPE: REPORTS OF WHO TOBACCO OR HEALTH MISSIONS

(continued from page 9)

cluding the Deputy-Minister of Health and Social Welfare, Dr Zbigniew Halat (see Editorial), are determined to do all that is possible to reduce its seriousness.

At a December 1992 symposium on options for tobacco control, WHO officials commented on two options for tobacco advertising control that were being considered in draft tobacco control legislation that is before the Polish Parliament. One would ban tobacco advertising partially, while the other would ban it totally. WHO officials pointed out that the World Health Assembly has recommended that Member States implement total bans on tobacco advertising. Moreover, a number of countries including Australia, Canada, France and New Zealand, having had partial bans on tobacco advertising and finding them to be ineffective public health measures, had now totally banned tobacco advertising. Poland was urged to profit from this experience and make the right choice for public health in the first place – a total ban on tobacco advertising. Comprehensive tobacco control, including tobacco advertising control options, are still under active consideration by the Polish Parliament.

Latvia

Tobacco advertising is nominally banned in Latvia, but the ban is often ignored by tobacco advertisers, and no action is taken to enforce it. Still, tobacco advertising is not nearly as widespread as in other countries of the Region, such as Hungary and Poland. A WHO/EURO consultant and a Finnish tobacco control official visited Latvia in January 1993 and strongly urged government officials to consider an effective ban on tobacco advertising as soon as possible. It was pointed out that there would be more resistance to a ban on tobacco advertising if attempts were made to implement such a ban later on, after tobacco advertising became widespread.

In recent months, a large Danish tobacco company has acquired a 45% interest in the Latvian tobacco industry. By the end of 1993, the Danish firm plans to launch a massive advertising campaign for its flagship brand using TV, posters, press advertising and tobacco kiosks. These plans only serve to emphasize the strategic advantage of banning tobacco advertising in Latvia sooner rather than later.

The Czech Republic

The Czech Republic, unlike several other countries of Central and Eastern Europe, has a legislated ban on tobacco advertising. Unfortunately, flaws in the texts of laws passed in 1989 and 1991 led to problems in applying and enforcing these laws. Members of a WHO mission that visited the Czech Republic in February 1993 strongly recommended that some careful legal revision be undertaken to ensure effectiveness of the ban on tobacco advertising. Shortly after the WHO mission, a third law banning tobacco advertising came into force in March 1993. But now a large transnational tobacco company, the new majority owner of the largest Czech tobacco company, by arguing that the legal texts are unclear, is seeking to have the total ban on advertising interpreted as only a partial ban on advertising. As this is written, the outcome of these negotiations is not yet known. Meanwhile, tobacco advertising continues with few restraints in the Czech Republic.

Cigarette smuggling is a serious problem in the Czech Republic and many neighbouring countries as well. WHO strongly recommended that representatives from all countries in the Region collaborate in finding solutions to this problem. Such regional collaboration is now underway and should soon result in improved control of cigarette smuggling in the Region.

Slovakia

The flawed legal texts in the Czech Republic mentioned earlier were all passed before the division of the former Czechoslovakia into two countries. As a consequence, the same flawed legislation is also applicable in Slovakia, and the same problems with barely restrained tobacco advertising, are present in Slovakia, just as in the Czech Republic. Fortunately, there is a strong and active public health community in Slovakia that will be urging the government to adopt effective tobacco advertising control measures, and include them in comprehensive tobacco control policies. The need is urgent. Currently tobacco kills about 11 000 Slovaks per year, but the annual number of tobacco-induced deaths is increasing more quickly than in the neighbouring Czech Republic.

The next steps

A good start has been made on developing comprehensive tobacco control programmes in the six countries discussed above. But continuing efforts will be required of public health officials and governments to ensure early implementation of effective, comprehensive tobacco control strategies. Moreover, tobacco use is also a serious problem in the remaining twenty-one countries of Central and Eastern Europe, and adoption of effective tobacco control strategies is no less important there. The WHO Tobacco or Health programme will continue to do all that is possible to bring international advice, assistance and encouragement to the countries of Central and Eastern Europe as they seek to implement comprehensive tobacco control strategies.

LEGISLATION

TOBACCO CONTROL LEGISLATION IN WHO'S EUROPEAN REGION*

Introduction

Many of the countries in the European Region have now introduced legislative measures to combat the pandemic of smoking and other forms of tobacco use. Furthermore, a unique feature of the European Region is the continuing harmonization of legislation, in the light of the important role of the European Community in combating tobacco use. This harmonization is affecting, and will increasingly affect, not only the Member States of the Community but also prospective Member States and neighbouring countries.

Control of tobacco advertising and promotion

France, one of the countries that has now enacted comprehensive legislation, can be selected as illustrative of current trends. A 1991 Law prohibits "any advertising, whether direct or indirect, for tobacco or tobacco products, as well as any form of free distribution thereof". It also prohibits any form of sponsorship "if its objective or purpose is direct or indirect advertising for tobacco or tobacco products". For the purposes of the Law, tobacco products include "products intended to be smoked, snuffed, chewed, or sucked, insofar as they are constituted, even partially, of tobacco, as well as products intended to be smoked even if they do not contain tobacco ...". Indirect advertising is considered to be "any advertising for an agency, service, activity, product, or article other than tobacco or a tobacco product whenever, on account of its logo, its presentation, or the use of a trade mark, advertising symbol, or any other distinctive sign, it is suggestive of tobacco or a tobacco product".

Smoke-free workplaces

According to information available to WHO, most countries in Europe have legislation that restricts smoking in the workplace. The scope and implementation of legislation varies greatly. In Sweden, the essential principle of the General Recommendations concerning smoking restrictions issued by the National Board of Occupational Safety and Health and the National Board of Health and Welfare in 1983 is that a smoker's desire to smoke should take second place to other people's desire for a smoke-free environment. Since 1988, 25 county councils have banned smoking on their premises. In 1990, an Interdepartmental Committee for Tobacco Control recommended that all workplaces should, in principle, be made smoke-free.

A new French law that came into force late in 1992 provides a large measure of protection from tobacco smoke in the workplace. However, Norway is currently the only country that provides general legislative protection of all workers from exposure to tobacco smoke at work. The legislation, which was introduced in 1988, is strongly supported by the population. In Finland, the Ministry of Health has announced that it aims to enact similar legislation.

Smoke-free public places

Restrictions on smoking in public places are among the most prevalent tobacco control measures. Belgium and France, having introduced their legislation recently, are among the countries with the most far-reaching protection from tobacco smoke. In Belgium, a Crown Order of 1990 prohibits smoking in enclosed places used by the public where, inter alia, education and/or professional training are provided, entertainment is offered, exhibitions are mounted, and sports are practised. In France, a Decree of 1992 restricts smoking in all closed and covered premises which are open to the public or which are workplaces. The ban is also applicable in public transport and, as regards public and private schools and colleges, in outdoor locations frequented by pupils and students.

Measures to combat smoking in public transport

A growing number of companies carrying passengers by road, rail and air are imposing increasingly stringent conditions aboard their vehicles. It is the airlines that have shown the most notable progress. For example, all flights of two hours' duration or less originating in France with French carriers are smoke-free, as are all flights between Nordic countries. The International Civil Aviation Organization (ICAO) adopted a resolution in 1992 calling on all contracting states to take measures aimed at introducing a complete ban on smoking on all international flights by 1 July 1996.

Health warnings and information on tar and nicotine

Provisions governing health warnings and tar and nicotine content are contained in a Directive of the Council of Ministers of the European Community, viz. Council Directive 89/622/EEC of 13 November 1989, as amended by Council Directive 92/41/EEC of 15 May 1992; this requires all packages of tobacco products to carry the general warning "Tobacco seriously damages health", and provides for Member States to choose from among 14 alternating specific warnings. Under the terms of Council Directive 90/239/EEC of 17 May 1990, the maximum tar yield of cigarettes was fixed at 15 mg, as from 31 December 1992, this figure being reduced to 12 mg as from 31 December 1997.

Mandating health education

Most countries have educational programmes on the hazards of smoking, but not all have enacted legislation making health education on tobacco mandatory, and even fewer have legislation that allocates funds to such programmes. However, a statutory requirement for education strengthens voluntary educational programmes, promotes the implementation of education, and makes a powerful contribution to the development of a nonsmoking society.

While effective health education may exist in the absence of legislation, the existence of legislation that mandates health education on smoking serves to express government policy and assures universal implementation of such education. Legislation also facilitates the provision of resources for health education on smoking. It can assure funding from the general government budget or provide for specific sources of revenue from tobacco taxes, or from other sources.

Four basic types of legislation requiring health education have been enacted: (a) general statutory requirements for health education on smoking; (b) requirements for health education on smoking in schools; (c) specific education requirements for high-risk groups; and (d) legislation concerning the allocation of financial support for health education programmes.

No legislation can be expected to succeed without education; equally, the impact of education is greatly enhanced by legislation. Legislation and education can be said to reinforce each other.

Comprehensive tobacco control legislation

Of course, the most effective legislative tobacco control strategy is a comprehensive approach that includes all or nearly all of the legislative elements discussed above. Such comprehensive legislation is currently in force in Iceland, Norway, Finland, Portugal and France.

Serious and active consideration is being given to the implementation of comprehensive legislative action for tobacco control in a large number of European countries including Austria, Belgium, Italy, Lithuania, Poland, Slovenia and Sweden. Hopefully, more and more countries will enact tobacco control legislation embracing most or all the components discussed above. If this happens, we can look forward to a Europe that is truly tobacco-free in the not-too-distant future.

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* The information contained in this article is based largely on the following source: KOEMEL P. Legislative Action to Combat the World Tobacco Epidemic. Second Edition. Geneva, WHO, 1993 (forthcoming). Additional information concerning tobacco control legislation in the Member States of the European Community is published in the following source: SASCO, A.J., DALIA VOKSA, P. & VAN DER EIJST, P. Comparative Study of Anti-Smoking Legislation in Countries of the European Economic Community. Lyon, International Agency for Research on Cancer, 1992. (IARC Technical Report Series No. 8).

COUNTRY PROGRAMMES

THIRD SEMINAR ON THE ACTION PLAN FOR A TOBACCO-FREE EUROPE: VIENNA, MARCH 1993

The Third European Seminar for national tobacco or health policy advisers and national programme managers was held in Vienna, from 11 to 14 March 1993, under the auspices of the European Action Plan on tobacco of the WHO Regional Office for Europe, and hosted by the Austrian Ministry of Health. About 80 participants came from 35 countries (as far apart as Iceland, Portugal, Israel and Tajikistan) and 12 major international organizations.

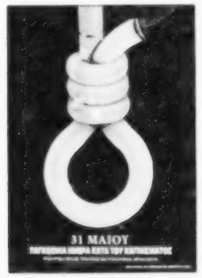
Comprehensive tobacco control legislation under consideration in Austria

WHO estimates that tobacco kills 11 000 Austrians per year. The meeting opened with the encouraging news that the host country, Austria, was considering tobacco control legislation, recently made public by one of the meeting's active participants, the Austrian Minister of Health, Sport and Consumer Protection, Mr Michael Ausserwinkler. The proposed new law, which follows the model proposed by WHO and promoted through the European Action Plan on tobacco, would restrict tobacco advertising to informative advertising only, and would be allowed only at points of sale. New warnings would be required on packages of cigarettes and there would be new authority to limit the allowable amounts of toxic constituents in cigarette smoke. Initial regulations would require maximum tar yields of 15 mg per cigarette in 1994 and 12 mg per cigarette in 1996, as recommended by European Community directives. Other provisions would restrict smoking to smoking areas or smoking rooms only, in most public places except bars and restaurants, thereby providing an increased measure of protection from involuntary exposure to tobacco smoke.

Meeting participants publicly endorsed the draft legislation at a news conference and suggested that further measures, such as using new tobacco taxes to fund health promotion, could also be considered.

Economics of a tobacco-free society

Participants then turned their attention to the main theme of the meeting, the economics of a tobacco-free society. Plenary and small-group sessions all focused on this theme, and on how knowledge from the fields of both public health and economics could be combined to advance the implementation of tobacco control policies throughout Europe. A highlight of the meeting was a presentation by Ms Rhonda Galbally, Chief Executive Officer of the highly successful Victorian Health Promo-



tion Foundation in Australia. This Foundation is funded by a 5% tax on the wholesale price of tobacco in the state of Victoria, Australia. The money so raised is used for tobacco sponsorship replacement, health promotion, health sponsorships, research, monitoring and evaluation (see Tobacco Alert issue of July 1990). In Europe, similar use of dedicated tobacco taxes for tobacco control and other health-related purposes exists in Finland, Iceland, Portugal and most recently in Romania; consideration is currently being given to the possibility of extending this process to a number of European countries.*

Recommendations

At the conclusion, meeting representatives recommended that WHO:

1. Promote greater knowledge and understanding on the economics of a tobacco-free society. Emphasis will be placed on the benefits to the economy of a healthy population and to the gains made by a shift of resources into economic activities which enhance and sustain life rather than causing its destruction and depletion.
2. Contribute particularly to a clearer understanding of the increasing damage done by tobacco to the economics of countries of Central and Eastern Europe. This evidence will be widely disseminated to hasten the transition of a tobacco-free Europe. Maximum use will be made of sub-regional workshops to share knowledge and train key workers.

Action items

In addition to these broad recommendations, participants called for action on a number of more specific items. In particular, they urged WHO to:

1. Encourage greater collaboration between ministers of health and finance in joint strategies to improve national economies by reducing tobacco use and production.
2. Press for high rates of tobacco taxation, with regular increases, based on a combination of specific, ad valorem and high minimum tax rates. At least 1% of the revenue collected should be devoted to health promotion activities. Tobacco taxes should be harmonized, where practical, to a high level to reduce smuggling, which should also be discouraged by methods including: tax stamps, licensing of retailers and adequate border controls.
3. Encourage all Member States to remove tobacco from retail price indexes in order to eliminate the disincentive to raise taxes because of the effect on inflation.
4. Ask Member States to increase their capacity for implementing policy on taxation by identifying suitably qualified individuals who can facilitate discussions with Ministries of Finance on taxation matters.
5. Commission a study of economic data linking price, consumption and basic tobacco market data in European countries. Member States will be asked to provide raw data to allow this analysis to be carried out.
6. Seek a Collaborating Centre to support the Regional Office in this endeavour.

*See also the article on Switzerland featured in this issue on page 8.

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Pictures of posters are from the database of tobacco education material maintained by the WHO Collaborating Centre for the Action Plan on Tobacco in Paris, the French Committee for Health Education.

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